Pediatric/Adolescent Screening and Immunization Documentation Form

2009-2010 Seasonal Influenza Vaccination Program

The following questions will help us determine if we should give your child the intranasal or the injectable influenza vaccination today. If you answer "yes" to any question, we will ask additional questions to determine which vaccine, if any, your child will receive. Please speak to your healthcare provider, if you have any questions.

Circle answers to questions 1-16:			
1	Is the child younger than 2 years of age?	No	Yes
2	Has your child ever received the flu vaccine?	No	Yes
3	Does your child currently have a respiratory illness or a fever?	No	Yes
4	Is your child taking any prescription medications to prevent or treat influenza? Have they taken antiviral medication in the last 48 hours?	No	Yes
5	Has your child ever had a serious reaction to a flu vaccine in the past?	No	Yes
6	Does your child have an allergy to any of the following: eggs, chicken or egg protein, gentamicin, gelatin, arginine, thimerosal, formaldehyde, or other vaccine components?	No	Yes
7	Does your child have a history of asthma or wheezing?	No	Yes
8	Does your child have an active neurological disease?	No	Yes
9	Does your child have a history of Guillain-Barre Syndrome (GBS)?	No	Yes
10	Does your child have heart disease, lung disease, kidney disease, metabolic disease (e.g., diabetes), anemia, other blood disorders or any other chronic health conditions?	No	Yes
11	Is your child taking aspirin or aspirin-containing therapy?	No	Yes
12	Has your doctor ever told you that your child has an immune system disorder? Is your child taking long-term steroid treatments or immunosuppressants?	No	Yes
13	Does your child have HIV, AIDS, or cancer? Have they had an organ transplant?	No	Yes
14	Does your child live with or expect to have close contact with severely immunocompromised individuals who must be in a protective environment (such as transplant recipients?)	No	Yes
15	Is the person to be vaccinated pregnant?	No	Yes
16	Has your child received any vaccines within the last 30 days or are they going to receive any additional vaccines within the next 4 weeks?	No	Yes

"I have read or have had explained to me the information in the 2009-2010 Influenza Vaccine Information Statement (VIS). I have also had a chance to ask questions and they were answered to my satisfaction. I understand the benefits and risks of the influenza vaccine."

Signature: _____ Date: _____

Below to be completed by healthcare provider

Give injectable flu vaccine today

Give intranasal flu vaccine today

Do not administer flu vaccine today

Interviewer's Signature	**Date**

Vaccine Administered

Live Intranasal Influenza (FluMist, MedImmune)
Lot # _____
Dose: 0.2 ml Route: Intranasal

Inactivated Influenza (Fluzone, Sanofi-Pasteur)
Lot # _____
Dose (6-35mo): 0.25mL Route: IM (6-12mo)Thigh
IM (>12mo) Deltoid
Dose (≥36mo): 0.5mL Route: IM Left/Right Deltoid

Name: **DOB:** **SSN:**	**Administered by:**	**Date**

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If you're not SURE that you've been seen or registered at Kenner Army Health Clinic

– please complete this portion

LAST NAME, FIRST NAME, M.I. _____

SPONSOR'S SSN: 20/_____ **DOB** _____

SEX (CIRCLE ONE**) MALE FEMALE RANK**_____

UNIT _____ **UNIT PHONE** _____

HOME ADDRESS: _____

LOCATION OF MEDICAL RECORDS _____

LIST ALL ALLERGIES AND SIDE EFFECTS SEEN: NO ALLERGIES _____

1. _____
2. _____
3. _____

DO YOU HAVE ANY OTHER HEALTH INSURANCE? ___YES ____NO

IF YES, PLEASE PROVIDE THE NAME OF THE HEALTH INSURANCE COMPANY _____